Senate Bill (SB) 553
Working Group on the Implementation Planning for the Incorporation of Nursing and Choices for Independence Waiver Services in the NH Medicaid Care Management Program

Public Working Session

October 20, 2016
10:30 a.m. – 12:00 p.m.
Legislative Office Building, Rooms 210-211
Concord NH

Introductions; Agenda; Announcements
Working Group members and interested parties were introduced. The agenda includes: presentations on Independent Case Management; Adult Day Programs; NH Nutrition Network/Meals on Wheels; and NH ServiceLink.
The next meeting on November 1 will be extended to 12:30pm. John Meerschaert of Milliman, DHHS' actuary, will provide a detailed presentation on the ratemaking process - how rates have been developed; as well as a construct for how rates will be developed for nursing services and waivered services in NH.

Choices for Independence (CFI) Independent Case Management:
Lisa Perales, VP of Nursing and Director, Population Health Management and Ann Schwartzwalder, Director, Community Care, Crotched Mountain (CM)
Program Overview:

- Choices for Independence (CFI) is a Medicaid program offering home and community-based services to chronically ill individuals and frail elders at risk of institutionalization. Case management facilitates the integration of all LTSS through conflict-free independent case management .
- The program offers an alternative to nursing home care for individuals who wish to live at home or in assisted living communities.
- Individuals must be 18 years of age and older, require nursing home level of care, and meet NH Medicaid income and assets requirements.
- Benefits and services include integration throughout the care continuum. CM is piloting a program with Portsmouth Hospital to coordinate with hospital ER staff to facilitate effective person-centered care.

Lessons learned - Step 1: Use a Care Coordination Ecosystem framework in which all case managers throughout the continuum (intensive care, acute care, post-acute care, community care, and payers) work together to streamline process flows.

The CM/Portsmouth Hospital pilot used Lean to develop process flows when a CFI client presents at the ER. Communications were analyzed to assess how long it takes to recognize the client was at the hospital. Universal client cards were issued to enable hospital case managers identify CFI clients and immediately reach out to the MCO and independent case managers. Gaps and temporary solutions were identified. This provides the opportunity to consider quality improvement at the systems level. Lessons learned from other states: Consider capacity factors: Population growth (baby boomers), network adequacy (mid-level care options required due to lack of nursing home beds and home care staff), and MCO staffing adequacy. Payment reform is needed to address inadequate rate structures,

denied claims, billing software, delays for authorization, and financial risk. There is no evidence-based LTSS model and no standardized quality tool.

Considerations for Step 2: Test assumptions: LTSS landscape (work together as a system vs. working in silos); gap analysis, needs assessment, integration of services, evidence-based utilization review, quality standards and metrics, LTSS system focus.

Comment: The IMPACT (Improving Medicare Post-Acute Care Transformation) Act is implementing measures and public reporting on hospitalization and re-hospitalization rates.
A: ICM is looking for efficiencies. The metrics are lining up and there is a lot of overlap in monitoring lengths of stay.

Q: Is the pilot for care coordination a hybrid model?
A: MCO and CM both have integrated care models. They put them together identifying critical information and how to augment their resources considering a partnership model for the overlap. This pilot is a positive step to creating the whole person approach.

Q: Are residential care clients provided the universal card?
A: Not yet because they started with a more narrow scope.
Comment: this will create overlap with residential care staff.
A: We should identify overlap

Q: How long has the Portsmouth pilot been in place?
A: Spent 5 months on design and planning. Universal cards recently distributed. The program launch is being initiated now.

Adult Medical Day Care in New Hampshire:
Paula Faist, NH Adult Day Services Association
Adult Medical day care programs provide comprehensive programming tailored to meet the needs of adults who require supervision and assistance during the day, thus allowing much needed respite for caregivers.

Adult medical day programs are paid $12,310 per year (250 days for 4-12 hours/day at $49.24/day) as compared to nursing home rates of $150-175/day - a savings of $46,000 per Medicaid client. Medicaid adult medical day care rates have not increased since 2007, but the average cost of providing care is $75-90/day. Massachusetts pays for two levels of care - (1) basic level of care per diem is $60; and (2) complex level of care is $76. Most Medicaid patients are complex level.

In NH, 258 Medicaid clients use adult day programs saving the state approximately $9.5 million in nursing home costs per year. Each adult medical day client has an individual comprehensive medical care plan based on diagnosis, level of care, and goals. RNs, LPNs and LNAs provide nursing care (vital signs, blood sugar monitoring, weight monitoring, and medication administration). Assistance is provided with ADLs, and the programs provide socialization. Clients are monitored and interventions are made before conditions worsen.

Programs have closed due to poor Medicaid funding. Eighteen programs remain, down from 33 since 1993. More programs are at risk of closing, while the need for Adult Day programs is growing. According

to the CDC, 75 percent of adults age 65 and older have chronic conditions, and will make up 19% of the population by 2030 (compared to 12% in 2000).

Step 2: Recommendations: (1) Need consistency of transportation companies. (2) Frequency of prior authorizations should be reduced for a population with chronic conditions and infrequent changes. This would reduce the paperwork burden for the MCO and ADMC. (3) Medication approvals should be more timely. With intervention by adult day care, a costly ER visit was avoided.

NH Nutrition Network (NHNN)/Meals on Wheels
Brooke Holton, Chair, NH Nutrition Network and Alex Koutroubas, Dennehy and Bouley
NHHN is a group of ten nutrition providers that contract with DHHS to provide services to elderly and disabled adults who are unable to shop, prepare meals, have limited mobility, limited access to friends and families, isolated, and have memory issues.. Members provide home-delivered meals, congregate dining, and transportation services. In SFY 2016, 753 Medicaid clients received 142,262 meals; 7,776 Non-Medicaid clients received $1.4 million meals.

The program reduces isolation and hunger, provides a built-in safety check and personal and consistent contact with clients, a way to identify problems before they worsen and referrals to needed services. Step 2: Concerns regarding quality of services. Will personal contact with client s be reduced; will it diminish the quality of the food?

Q: How will delays in eligibility change under Step 2?
A: Uncompensated care is a problem. The programs subsidize unpaid meals with grants and fundraising; and they are not paid for all the work they do. Rates have not increased since 2007. The system cannot be sustained with no rate increases. Programs are concerned about negotiations with national MCO companies. The NHNN agencies do not have the requisite level of sophistication.

Q: What are the sources of funding?
A: Social Services Block Grant, Medicaid CFI, and the Older Americans Act. The programs are not allowed to use funds from other sources for Medicaid patients.

Q: Who decides how many meals a client receives?
A: The state determines the number of units each client receives.

ServiceLink: Aging & Disability Resource Center:
Wendi Aultman, Administer No Wrong Door System/ServiceLink
Jennifer Seher, Program Director, Monadnock and Sullivan ServiceLink

ServiceLink is designated as New Hampshire's Aging and Disability Resource Center and the NHCarePath Full Service Access Partner providing guidance, support, and choice for individuals of all ages, income levels and abilities.

Aging Disability Resource Centers (ADRCs) and No Wrong Door Systems of Access (NWD) for Long Term Services and Supports: NWD systems serve as the entry point to publicly administered LTSS, including those funded under Medicaid, the Older Americans Act, the Veterans Health Administration. In NH, the ADRC is branded as ServiceLink and the NWD system of access is branded as NHCarePath.

NWD Systems serve as highly visible places in every community where people go to receive information and counseling on the full range of long-term support services options. They provide a person-centered, single, coordinated system of information and access within a community-based environment that promotes independence and dignity; easy access to information and counseling; and resources and services that support the needs of family caregivers.

Multiple statewide partners collaborate as part of NHCarePath to make it easier for NH residents to find and connect to the help they need. It reduces the financial burden on the state's public programs, including Medicaid. For example, the No Wrong Door System helps to divert individuals from long nursing home stays by providing alternative long-term options; the data indicates that the likelihood of becoming Medicaid eligible increases with longer nursing facility stays.

ServiceLink contracts with local agencies to help individuals access guidance, support, and choice related to LTSS for all populations and payers; access family caregiver information and supports; and explore options and understand and access Medicare/Medicaid.

The role of ADRCs will evolve and expand to fill in gaps in the provision of information, referral, counseling and streamlining access to supports as service delivery and financing systems in the state change. Managed Long-Term Care (MLTC) programs will likely play a role as states restructure systems of care. ADRCs will need to be part of those discussions.

ServiceLink's Role with Step 1: Health literacy; in-person, confidential assistance at no cost; review of plan options; education on choosing a plan and enrollment; outreach and education to MCO; consultation source for MCO

ServiceLink Lessons Learned with Step 1: challenges due to staff and operational capacity; communications to the client must be clear and simple; public forums were helpful but need more outreach to get to rural "pockets"; clear direction on who to contact throughout the process; ServiceLink staff need to be trained prior to the roll out; timing of the roll out should consider overlap with high volume periods; and access to Eligibility System was helpful.

Considerations for SB 553: provide prevention/cost deterrence strategies such as supporting family caregiver and caregiver education; invest in existing partnerships and infrastructure; leverage existing shared data and IT to connect people to resources; invest in supports that prevent or prolong the need for MLTSS; and leverage ADRC and NWD System to enhance MLTSS

ADRC roles: As highly trusted and visible places for LTC information, ServiceLink can have a role in contributing to the design of MLTSS, to include providing information to Medicaid about needs in the community (especially for difficult to reach populations at risk of institutionalization); offering valuable insights on how proposed program designs will impact consumer needs and preferences; coordinating eligibility; providing enrollment counseling; advocating on an individual level; training MCO case managers on availability of community resources; providing person centered options counseling to those transitioning from acute care or nursing facility to community.

Next Meeting

The next meeting will be held on Tuesday, November 1, 10:30am-12:3pm at the Legislative Office Building, Rooms 210-211.